VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

December 2, 2011

Ms. Paula Patorti, Administrator
Our House Outback
196 Mussey Street
Rutland, VT 05701

Provider #: 0593

Dear Ms. Patorti:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **June 2, 2011.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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Enclosure

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Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING _____ B. WING _____	C 06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	196 MUSSEY STREET RUTLAND, VT 05701

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R100	Initial Comments: An unannounced onsite re-licensing survey and complaint investigation were initiated by the Division of Licensing and Protection on 5/12-5/13/11, and completed on 6/2/11 after further offsite investigation. Findings include:	R100		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to assure the necessary provision services to meet each resident's nursing and medical care needs by failing to assure a timely physical assessment for 1 applicable resident (Resident #1) in the survey sample. Findings include: 1. Per record review on 5/12/11, Resident #1 sustained a fracture as a result of a physical altercation with Resident #2 on 4/6/11. Immediately following this observed incident, the charge staff notified the RN (Registered Nurse) via telephone of the incident and reported that Resident #1 had fallen to the floor and had a head injury, prior to obtaining vital signs or moving the resident. Staff were advised to help the resident arise, to apply ice to the head and hip area, to monitor for changes, and to call the RN back if there were any changes in the resident's	R126 R126	The owners and management team at Our House Outback take regulations; and Compliance with such, Very Seriously. Residents will get an onsite evaluation by the RN whenever there is a change in medical status or For any injury that requires such. RN's Quoted Clarification of fall incident. "I received telephone call reporting an incident between two residents, resulting in Resident #1's being pushed against the wall, then she slid down the wall. Staff reported she had hit her head and landed on her Left side. Staff reported that two staff members assessed her as she was trying to stand, and they assisted her to a standing position and walked her to a chair. I instructed staff to apply ice to bump on head and give tylenol if she complained of pain or discomfort, i.e a headache.	

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R126	Continued From page 1 condition. Per interview with all staff present at the time of the injury and with 1 of 2 night staff, and 1 day staff (following morning), Resident #1 was unable to bear weight, or walk normally following this incident. No staff member called emergency services. A second telephone contact was made by charge staff 3 hours later to the RN, indicating that the resident was unable to bear weight on the left leg and was experiencing pain with mobility attempts. Three staff members caring for Resident #1 indicated that immediately following the fall, Resident #1 was unable to bear weight on the left leg and that the RN did not arrive to assess the resident's injuries following either the first or second notification. The following morning, the RN assessed Resident #1 and initiated an Emergency Room evaluation. During interviews on the mornings of 5/12/11 and 5/13/11, the RN denied knowledge of pain and lack of mobility by the Resident and stated that staff are trained and should have called emergency services prior to notification of the RN if a serious injury was suspected.	R126	Also instructed staff to do a full body assessment and to watch for redness or swelling in the legs, hips and head or any Complaint of pain. I never received a call from the overnight staff reporting any findings of Complaints of pain. Resident was assessed by me at 7:15 the next morning. I arrived to find her sitting in a wheelchair, smiling and not verbalizing any complaints. I performed range of motion while she was sitting in the chair and then with the assistance of two staff members we stood her up, she did NOT verbalize or grimace in pain with weight bearing. Upon returning her to the sitting position I noticed facial grimacing, at which point the MD was notified and advised transport to the ER for evaluation. Her daughter was notified at this point."	
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by:	R126 Cont'd R128 R126 Cont'd	All reports of resident falls will be thoroughly questioned when the report is made and use of the new Reporting Forms, Call and Communication logs. Report will be filled out by the receiving Nurse so she is asking the same questions and documenting the answers for accuracy comparison, to make sure that all is understood and will follow up with shift incident reports making sure that staff and RN communications are the same. Call logs have already been implemented. Reports will be monitored by the MGR and RN for accuracy within 24 hours of incidents.	8/1/11 6/30/11

R126 POC accepted 11/28/11
Claraway RN/DMcotarn

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R128	Continued From page 2 Based on record review and interview, the home failed to assure that physician orders were carried out for 1 of 4 residents in the survey sample (Resident #4). Findings include: 1. Per record review on 5/13/11, current physician orders for Resident #4, diagnosed with orthostatic hypotension (blood pressure drops with rising from lying to sitting to standing) included "BP (blood pressure) QID (four times daily) while sitting, standing, lying down after meals and at HS (bedtime)". Review of the record did not indicate that this order was being completed in each required position at each required time. During interview that afternoon, the Manager confirmed that the blood pressure readings for this resident were not being completed as ordered.	R128 R128	Resident #4 becomes very agitated with frequent touching due to his disease. Blood Pressures were taken as allowed and recorded on the M.A.R. An order will be obtained from the Physician to decrease frequency of BP monitoring as there have been no medication changes in three months. (Pending) 7/29/11 Physicians orders will be monitored for accuracy by the RN and the house managers; as changes arise the RN will Coordinate orders with the Physician, all records will be reviewed monthly for accuracy and compliance by the house manager. R128 POC accepted 11/28/11 Clarawayers/RN cotaRN	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN (Registered Nurse) failed to assure that the plan of care for 2 of 4 residents in the survey sample (Resident #1 and Resident #4) contained identification of all care needs and direction to staff regarding those assessed needs. Findings include:	R145	Resident #1's assessment was updated upon return from the hospital but NOT the Care plan. Changes of Care were given to the staff Verbally. All Significant Changes will be reflected on the resident assessment and on the Care plan as they occur. New Care plans will be done or at least updated with annual and Status Change prompted assessments. New CARE plan forms have been adopted and will start utilization no later than August 1, 2011. 8/1/11	

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R145	Continued From page 3 1. Per record review on 5/12/11, Resident #1 had returned from a hospitalization requiring the assistance of 2 staff for all transfers / mobility both in and out of bed. The Resident Assessment Instrument (RAI) was last updated on 4/11/11 to indicate this new need. The resident also required physical therapy for strengthening / rehabilitation following return from the hospital. The plan of care, signed by the RN on 7/2/10, was not revised to indicate these new care needs. During interview on 5/13/11 at 7:35 AM, the RN confirmed that the RAI indicated new mobility and care needs and that the plan of care was not updated to include this new information for daily caregivers. 2. Per observation on the morning of 5/13/11, Resident #4 was seated in a wheelchair wearing a seat belt. Per record review, there was no indication of the use of this seatbelt or wheelchair on the plan of care. The record also indicated a physician order to assure a daily fluid intake of at least 1.5 liters and to add extra salt to the resident's daily diet. During interview that morning at 9:50 AM, a staff member confirmed that the plan of care (signed by the RN on 8/7/10) did not include information / instruction to staff regarding the use of a wheelchair and seat belt or special dietary instruction regarding fluids and extra sodium requirements.	R145	1) Care plan has been updated to reflect the seat belt application. Items such as fluid requirements and dietary orders are written in our memo book so all staff received the communication, as the staff does NOT read the care plan everyday for every resident. Changes are verbally communicated at shift changes. New shift Report form will help All staff to have a more accurate account of what each shift has done. (See care plan included) CARE plan has been reviewed with all staff. All resident Care plans are to be reviewed Frequently by all staff. RN's are responsible to keep the Care plans current. House manager and owner will monitor AS Needed for accuracy and no less than monthly for dual Verification. R145 POC accepted 11/28/11 Claraway RN / Amcotarn	7/10/11
R147 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (4) Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date	R147	The OTC PRN Standing orders are the ones we have used for more than six years now, on previous surveys, it has never been communicated to us that ranging those meds was NOT allowed and they have always been approved by the Physicians. Most staff call	

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R147	Continued From page 4 medication ordered; dosage and frequency of administration; and likely side effects to monitor; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that physician ordered medications contained specific dosages and times for 4 of 4 residents in the survey sample (Resident #1, Resident #2, Resident #3 and Resident #4). Findings include: 1. Per record review on 5/13/11, Residents #1 through #3 had physician signed standing orders with multiple examples of ranges of dose and / or times. Examples include: Acetaminophen 325 mg (milligrams) PO (orally) Q (every) 4-6 {sic. hours} for pain or fever, Extra strength Acetaminophen 1 or 2 tabs Q 4 hours for general discomfort / Malaise, Ibuprofen 200mg 1-2 tabs PO Q 4-6 {sic. hours} PRN for pain, Liquid Antacid 2-4 tbsp (tablespoons) PO PRN between meals and / or at bedtime for indigestion. During interview on 5/13/11 the RN (Registered Nurse) confirmed that all 'house' standing orders contain range of times / doses. 2. Per record review on 5/13/11, Resident #4 was administered a 'basic supp' on 4/5/11 and on 4/28/11. Also given per MAR (Medication Administration Record) was Tylenol on 4/16/11 and on 4/29/11. Neither of these orders, handwritten on the MAR, contained dose, frequency, or reason for administration. During interview that afternoon, a staff member confirmed that these medications were on the MAR, that the MAR indicated they had been administered, and that no dose, frequency, or reason for administration was included in the	R147	the RN on duty before giving any medication that is ranged and report the reason for giving the medication. our plan is to rewrite our standing orders for OTC PRN's, removing ranges. All M.A.R. have been corrected and are now and will remain in Compliance. All med certified staff are aware of regulations and expectations. MAR will be monitored by the RN for accuracy and Compliance. House manager will monitor at least monthly or as changes occur. R147 POC accepted 11/28/11 Clara Mayer RN/ Pm Coburn	9/1/11

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R147	Continued From page 5 transcription.	R147		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to assure that 1 applicable resident in the survey sample (Resident #3) had a behavioral plan to direct the use of PRN (as needed) psychoactive medication. Findings include: 1. Per record review on 5/13/11, Resident #3 receives Seroquel 25 mg (milligrams) Q (every) 6 hours PRN for Agitation. There was no behavioral plan in the record to direct unlicensed, medication delegated staff regarding the proper use of this medication. During interview that afternoon, the Manager confirmed that there is no behavior plan for this medication for Resident #3.	R167	This was an oversight that has since been rectified. All behavior plans are current and will be monitored for accuracy by the RN and house manager on a case by case basis. Monthly reviews will assure Compliance. R167 POC accepted 11/28/11 Claraway RN/Director RN	7/10/11

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R171	Continued From page 6	R171		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to maintain a current list of delegated staff administering medications and to assure that delegated staff properly documented PRN (as needed) medications administered to 2 applicable residents in the survey sample (Resident #1 and Resident #3). Findings include: 1. Per review of the home's delegation list (Med Certification List) on 5/12/11, two staff persons	R171	Previously experienced delay of adding New med Certified Staff has been resolved. RN will add new member to the master list at the time of Certification and Communicate Change to House manager. R171 POC accepted 11/28/11 Caraway RN/ Director	6/10/11

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R171	Continued From page 7 identified as giving medications were not included on the most recent certification list. During interview on 5/12/11 at 3:10 PM, the Owner / Manager confirmed that 2 staff currently giving medication were not on the 'Med Certification List'. 2. Per record review on 5/13/11, Resident #3 had an order for 'Seroquel 25 mg (milligrams) 1 tablet PO (orally) Q (every) 6 hr agitation PRN (as needed) and was administered this medication multiple times daily from 5/1/11 to the present. There was no documented reason for this medication administration nor was the effect noted following any administration except on 5/3/11 at 4:00 AM. During interview that afternoon, the Manager confirmed that this medication was administered per the MAR (Medication Administration Record) and that the MAR did not indicate either the reason for or results of this PRN medication administration on any occasion except 5/3/11 at 4:00 AM. 3. Per record review on 5/12/11, the Medication Administration Record (MAR) indicated that Resident #1 received oral Acetaminophen on 9 occasions from 4/6/11 through 4/22/11. Staff did not appropriately complete the MAR either indicating the administration of the medication on the front page and / or did not indicate the number of tablets / dosage and / or did not indicate the effectiveness of the medication. During interview on the morning of 5/13/11, the RN confirmed that the MAR was incomplete.	R171	The RN and owner have and will continue to review Survey results with all med Certified Staff. All are aware of the seriousness of accurate documentation for all medications. RN will monitor MAR on a monthly basis or as orders change, for accuracy and Compliance. House manager will dual verify M.A.R. at least monthly or as changes occur. New training modules have been adopted and will be utilized as a refresher and tester for all med Certified staff. R171 POC accepted 11/20/11 Claraway RN/PMcotaRN	7/1/11
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services	R179		

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R179	Continued From page 8 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, 4 of 4 employees did not have either required annual training components or 12 hours of total annual training. Additionally, 3 of 5 staff indicated they had received no training regarding abuse / neglect reporting requirements. Findings include: 1. Per record review on 5/13/11, no staff member in the survey sample had completed the required annual training on 'Respectful Effective Communication' and 3 of 4 staff had not completed the annual required 'Fire Safety' training. 2 of 4 staff had not completed 12 hours of total annual training. During interview that	R179	Every minute of everyday is a day for on the job training and that will never change as it would truly be impossible to teach each and every scenario in a classroom setting. Admittedly in service training has always been a challenge, therefore with the verbal OK from the surveyor at a previous inspection, at a sister house, we have implemented a written manual for work study - Complete with training info and written skills tests that will be maintained for each staff member. None of the STAFF interviewed had been employed for 12 months at the time of survey. We have a new and exciting resource that should make these interesting training sessions hoping this will prompt better participation.	6/7/11

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R179	Continued From page 9 afternoon, the Owner / Manager confirmed that these employee records did not indicate all required training and / or hours. 2. Per unlicensed staff interviews on 5/12/11, 5/13/11, 5/24/11, and 5/26/11, 4 of 4 staff stated that they had received no training and had no familiarity with written policy and procedure emergency response for accidents or injuries. During interview on 5/26/11 at 1:30 PM, the Licensee confirmed that the home has no written policy and procedure directing staff in emergency protocols regarding injuries or accidents. 3. Per unlicensed staff interviews on 5/12/11, 5/24/11, and 5/26/11, 3 of 5 staff denied awareness of /or training regarding reporting requirements for suspicion of abuse / neglect. No staff member interviewed was able to indicate the mandated timeframe for reporting suspected abuse / neglect.	R179	2) We practice the Simple method especially when it comes to urgency/Emergency - Basically we train staff that aside from an obvious situation to call for immediate help (911) they are to contact the manager, owners or RN for instruction on a case by case basis. All Policys and Procedures have been approved by DAIL and they have never contained a "written Policy or procedure Emergency response for accidents or injuries" However we are presently implementing one with the help of our Newest resource. 8/1/11 3) All staff are shown where the written policy regarding "reporting of suspected abuse and neglect" is laminated and posted on the wall. All are expected to know where this reference is and how to interpret it's expectations. This review will be added to our Orientation checklist so that a signature proves that we have gone over it with each of them. 8/1/11 We are working with an attorney in creating an employee handbook that will allow our staff to a written guideline to follow for both OUR House and State requirements. All staff will be expected to sign a Statement of understanding. on going testing is expected on an annual basis.	
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not have the results of all criminal background checks for 1 applicable staff member in the survey sample. Findings include: 1. Per record review on 5/13/11, one employee re-hired within the past year had no results of a criminal background check. During interview that	R190		

R179 POC accepted 11/28/11
Clara Way RN & Mostaro RN

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R190	Continued From page 10 afternoon, the Owner / Manager confirmed that the record did not contain the results of the Vermont Criminal Information Center (VCIC) check for 1 employee in the survey sample.	R190	This was an oversight or a computer error - we are very diligent in checking backgrounds, even of our student employees who only work a few months a year. We will continue to check all employee backgrounds prior to hiring.	7/1/11
R194 SS=D	V. RESIDENT CARE AND HOME SERVICES 6.14 Restraints 6.14.a Mechanical restraints may be used only in an emergency to prevent injury to a resident or others and shall not be used as an on-going form of treatment. The use of a mechanical restraint shall constitute nursing care. This REQUIREMENT is not met as evidenced by: Based on observation and interview, 1 applicable resident in the survey sample was in a mechanical restraint. Findings include: 1. Per observation on the morning of 5/13/11, Resident #4 was seated in a wheelchair wearing a seat belt. The resident was able to self propel in the wheelchair but was unable to release the velcro belt when requested to do so. Per record review, a physician order authorizing the use of a seatbelt dated 1/3/11 stated 'approval for seat belt for wheelchair, keeps sliding out' but no instruction regarding this use was provided. During interview at 8:50 AM on 5/13/11, the staff person in charge confirmed that the resident had an order for the seatbelt, that the resident was capable of ambulation, was at risk of falling, and was unable to release the belt as requested at that time.	R194	R190 POC accepted 11/28/11 Claraway RN/ PMcotaRN This resident has Lewy body dementia, he has good moments and NOT so good moments. The seatbelt is only for his safety, it is expected that staff assist him with his seatbelt when necessary. And that, as with every resident the amount of time spent in any one place is limited to a maximum of two hours. This is not a restraint but a safety device as ordered or intended by the Physician and requested by his wife. Physician has been advised of the Surveyors Concerns, he is editing his previous orders for Compliance. Off will create/maintain a checklist for time spent in seatbelt. Resident can release the seatbelt. When he wants, we will be tracking that daily on the checklist.	9/1/11 12/1/11

R194 POC accepted 11/28/11
Claraway RN/ PMcotaRN

11/22/11

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING _____ B. WING _____	C 06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OUTBACK	196 MUSSEY STREET RUTLAND, VT 05701

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R208	Continued From page 11	R208		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on interview and record review, the licensee failed to report a resident to resident altercation resulting in an injury. Findings include: 1. Per record review on 5/13/11, Resident #1 was verbally and physically assaulted by Resident #2 on 4/6/11 with a resulting fracture. The home sent no report of this incident to the Licensing Agency. Resident #1's family was notified only that the resident had fallen and not that this fall was the result of Resident #2's actions. During interview on 5/13/11, the Licensee confirmed that this incident had occurred, that Resident #1's family had not been notified of the full circumstances of the fall with injury, and that the Licensing Agency was not notified.	R208	R208 we are a special care unit caring for people with dementia, these people do not intentionally hurt each other, therefore the word Abuse in our opinion is inappropriate; however in respect of the State Surveyors interpretation, it will be handled differently if this situation ever arises again. Resident #1 (after speaking with his wife and physician) was transferred to a Geri psych hospital in MA for eval. within 48 hours of the incident where he spent approximately two weeks, was returned to us on Comfort Care and died two days later. Regs have been reviewed with RN's, MgRs and staff to assure Compliance.	6/2/11
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation	R247	R208 POC accepted 11/28/11 Claraway RN/ Pheotar RN	

Paula Patto 11/22/11

Division of Licensing and Protection

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R247	Continued From page 12 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the home failed to assure regular temperature monitoring of food storage equipment. Findings include: 1. Per observation and record review during the initial environmental tour, there were no documents indicating regular monitoring of a refrigerator and a freezer in the food storage area. During interview with the home's Manager at the time of the tour, there is no system in place to regularly monitor the temperatures of these appliances used for resident food storage.	R247	Monitoring of temperatures are done routinely by one of the owners though the June 1st walk-through had NOT been done at the time of the survey. We were unaware that "a monitoring report" was to be maintained in the home as the regulations do NOT state that, Nor have we been told that in the past. A Flow sheet was Created and presented to the Surveyor prior to her departure. R247 POC accepted 11/28/11 Claraway RN/ Amotaran	6/2/11
R251 SS=C	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to assure that all foods were protected from contamination. Findings include: 1. Per observation during the initial environmental tour on 5/12/11, a full 50 pound	R251	This is a secured, well maintained storage closet, Both the potatos and the Case of soft drinks were in sealed packaging as received from the Supplier therefore the manager felt that they were Safely Stored. Products were moved immediately and everything is Now placed on a shelf. R251 POC accepted 11/28/11 Claraway RN/ Amotaran	6/2/11

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R251	Continued From page 13 bag of potatoes and 8 two liter bottles of soft drink were stored on the floor of the storage closet. This observation was confirmed by the Manager at 9:40 AM.	R251		